

Status and Health Security: An Exploratory Study of Irregular Immigrants in Toronto

Laura Simich, PhD¹

Fei Wu, MSW²

Sonja Nerad, MSW³

ABSTRACT

Background: This qualitative study explores experiences of living without regular immigration status and implications for health security among irregular migrants in Toronto. Irregular migrants include those who lack secure status in Canada, including visitors who overstay visas; refugee claimants awaiting status determination; and failed claimants remaining in the country without authorization, awaiting deportation or following alternative procedures when judicial appeal is impossible.

Methods: In-depth, semi-structured interviews were conducted with irregular migrants recruited at a downtown community health centre. Interview transcripts were coded and analyzed using grounded theory and qualitative analytical techniques. The theoretical framework employed anthropological metaphors of liminality and examined psychosocial factors associated with stress.

Findings: Experiences of the study sample counter popular assumptions about irregular immigrants. The majority of study participants came to Canada to escape violence as well as lack of economic opportunity in home countries in Latin America, and most have tried to follow correct immigration procedures. Most are parents working in low-paying, exploitative jobs. They have attempted to lead productive and meaningful lives, but lack social support beyond the immediate family. They showed signs of suffering from trauma, depression, chronic stress, family separation and stress-related physical illnesses. Despite expressing self-esteem and using personal coping skills effectively, many reported unmet health needs and described barriers to help-seeking. Beyond the individual, the greatest impact of living without status appeared to be on the family, especially the children.

Conclusions: More comprehensive information about this growing population is needed for health promotion, provision of mental health services and fair policy formulation.

MeSH terms: Immigration; legal status; community health care; mental health

La traduction du résumé se trouve à la fin de l'article.

1. Scientist, Social Equity and Health, Centre for Addiction and Mental Health, Toronto, ON; Assistant Professor, Culture, Community and Health Studies, Department of Psychiatry, University of Toronto
2. Research Analyst, Social Equity and Health, Centre for Addiction and Mental Health; Culture, Community and Health Studies, Department of Psychiatry, University of Toronto
3. Director, Community Health Programs, Access Alliance Multicultural Community Health Centre, Toronto

Correspondence: Dr. Laura Simich, Social Equity and Health Research, Centre for Addiction and Mental Health, 455 Spadina Avenue, Toronto, ON M5S 2G8, Tel: 416-535-8501, ext. 7618, Fax: 416-979-0564, E-mail: laura_simich@camh.net

Acknowledgements: We are grateful for the help of Access Alliance Multicultural Community Health Centre, and for the financial support of the Dean's Fund, Faculty of Medicine, University of Toronto. We thank Mary Roufail and Julie Mooney for valuable research assistance. We also thank the women and men who came forward to share their personal migration and health experiences.

Attaining legal status and health security are urgent problems for a growing number of immigrants.^{1,2} Irregular migration confounds national immigration policy and tests the limits of human rights. Like the people affected, public health and social implications are hidden and understudied, but health care challenges are significant.^{3,4} For example, people without status accounted for one third of the total increase in the number of uninsured adults in the United States between 1980 and 2000.⁵ They also use disproportionately fewer medical services and contribute far less to public health care costs in relation to their population share.⁶

In this article, we use the term “irregular” to describe immigrants who lack secure legal status in Canada, including visitors who overstay visas; refugee claimants awaiting status determination; and failed claimants remaining in the country without authorization, awaiting deportation or following alternative procedures when judicial appeal is impossible.⁷ Variations in immigration status, or lack thereof, determine degree of access to health care and benefits.⁸ However, our primary interest is not eligibility for health care *per se*, but rather health insecurity and mental distress due to prolonged uncertainty and possible trauma related to the irregular migration and integration process.^{9,10}

Several pathways can lead to having irregular status. The size of the population in Canada is currently unknown; however, Canada uses a working estimate of about half a million unauthorized immigrants.¹¹ Immigration categories that confer “precarious” status and disproportionately affect women – temporary visas, family sponsorship and the live-in caregiver program – account for 72% of incoming immigrants in Canada.¹² Labour unions estimate that over 200,000 unauthorized workers are employed in Canada's underground economy. As well, 60% of approximately 250,000 refugee claims adjudicated in Canada since 1997 have been rejected and many claimants remain in the country without health insurance.¹³

Health needs, determinants of health and access to health care

Like other marginalized migrant populations, irregular migrants have significant unmet health needs,¹⁴ including treatment

for workplace injuries, prenatal care,¹³ and mental health.¹⁵ Typically, irregular workers hold risky or precarious jobs for lower pay than regular workers and are afraid to report exploitation.^{16,17} Irregular migrants tend to surface in deprived urban areas where immigrants concentrate and to be more ill when they do seek services.^{18,19} Few studies of emotional health among 'illegal' migrants exist, but one found associated positive and negative factors.²⁰ Studies of asylum seekers have noted anxiety,⁹ lack of control, a sense of isolation, and a crisis of identity brought on by criminalization.²¹ A recent study in Europe found that a majority reported chronic health problems, delayed care and being ill-informed about their rights; 70% of "theoretical beneficiaries" reported not having access to the health care to which they were entitled.²²

In Canada, irregular migrants must pay for most health services and hospitalization. Refugees and refugee claimants can apply for the Interim Federal Health Program (IFHP), which covers some essential services; however, federal coverage is inadequate, and provincial coverage, inconsistent.^{8,12} Service providers and migrants testify that migrants avoid health and social services for fear of deportation.²³⁻²⁵ Most irregular migrants remain excluded from public health care by the limited capacity of community health centres that may accept the uninsured, program eligibility rules, and barriers facing all newcomers.

To understand experiences and health needs of irregular migrants, we conducted a qualitative study at a downtown Toronto community health centre. The main research question was, how does living with irregular status affect mental well-being and social integration? Our theoretical approach employed an anthropological metaphor of liminality²⁶ and focused on psychosocial risks inherent in life transitions. The risk for irregular migrants is being trapped 'on the threshold' of society without achieving legal status and social incorporation. They are legally marginal, physically "deportable,"²⁷ and psychologically vulnerable. Due to space limitations, we present summary findings related to mental well-being, describing migration and settlement circumstances of study participants and challenges to psychosocial health.

TABLE I
Description of Study Sample

Demographic Variables		Number of Participants
Country of origin	Costa Rica	3
	Argentina	3
	Mexico	2
	Ecuador	2
	Peru	1
Age range (years)	20-29	2
	30-39	5
	50-59	3
	≥60	1
Status on arrival	Refugee claimant	6
Marital status	Visitor's visa	5
	Married	6
	Single	3
Educational level	Separated	2
	Professional / University	4
	Secondary	4
Occupation – Home country	Less than Secondary	3
	Professional	4
	Management/Clerical	4
	Self-employed	1
Occupation – Canada	Labour	2
	Labour	9
	Unemployed/unpaid	2
English proficiency (Self-reported)	Good	2
	Fair	5
	Poor	4

METHODS

Study design and setting

Qualitative and community-based methods are appropriate for exploratory research and to describe experiences from participants' own perspectives.²⁸ A collaborative approach between experienced researchers and a community health centre that prioritizes underserved immigrants fostered rapport with this hard-to-reach population.²⁹ Access Alliance Multicultural Community Health Centre (AAMCHC) has more than 15 years experience delivering health and social services to disadvantaged immigrants and refugees. Approximately 50% of AAMCHC clients have irregular immigration histories and status. Research ethics boards of the Centre for Addiction and Mental Health (a hospital affiliated with the University of Toronto) and AAMCHC each granted ethics approval. Researchers discussed relevant issues with an advisory group assembled by AAMCHC. This group helped develop a purposive sampling frame that was necessarily opportunistic due of lack of available data on the study population.³⁰ We recruited only Spanish-speaking participants for reasons of homogeneity and feasibility, although irregular migrants are found in many ethnocultural populations in Canada.

Sample and recruitment

The study sample included adults (8 women, 3 men) diverse countries of origin,

household sizes and migration circumstances (see Table I). Study participants had arrived in Canada in 2000 or later with one exception. Eight participants had two or more children under age 18. Two had grown children; only one had none. Gender imbalance in the sample is unsurprising; 66% of clients attending another Toronto health clinic for uninsured migrants were female.¹³ This study sample cannot be representative of the irregular migrant population, especially males. Study participants using services at AAMCHC were likely better off than those without such health care access. However, their experiences illustrate and help define psychosocial issues for further investigation.

Two Spanish-speaking Research Assistants (RAs) who were current or former health centre staff recruited participants through clinic and community networks. They distributed information letters in Spanish that described the study purpose and emphasized confidentiality. As expected, recruitment was initially difficult, but eased as trust was established. We abbreviated recruitment in 2005 to avoid exposure of participants fearful of increased deportations taking place at the time.

Data collection and analysis

Five key informant interviews in immigrant service, labour, legal and faith-based organizations provided background infor-

mation and helped define topics for in-depth interviews. Access Alliance provided a safe and supportive environment for interviewing migrants. We obtained prior informed consent and protected participants' anonymity by using only numerical identifiers on data records. Interview topic guides were semi-structured and open-ended. Because many factors interact to affect immigrant and refugee health,³¹ we included several common topics in all interviews: pre-migration experiences, arrival and settlement in Canada; the immigration process, the impact of lack of status on work and family; social support; and health status and health care experiences. Health-related questions included "Have you or anyone else close to you experienced health problems?" and, to understand psychosocial health, "How do you feel most of the time?" Interviews conducted by the lead investigator or an RA averaged 1.5 hours, with trained cultural interpreters arranged through AAMCHC. All interviews were audiotaped with permission. Participants gladly shared their experiences, but on occasion showed emotional distress. For ethical reasons, interviewers did not press for details of trauma, but offered support and referrals if desired. Participants received honoraria of \$25.

Spanish-speaking RAs transcribed the interviews and verified translations. Using NVivo software, two RAs coded transcripts, which were reviewed by the lead investigator and the senior research assistant. The initial coding framework followed the main topics of the interviews for comparison across cases. The second level of analysis regrouped topics into defined stages of the migration process (separation, transition, incorporation), focusing on emerging themes related to psychosocial stress.

RESULTS

The reason for coming to Canada reported by most migrants was not primarily economic gain, although economic instability was often an additional 'push factor'. Rather, most sought increased personal security; that is, to escape acts of violence such as political terrorism, police harassment, criminal threats and sexual violence. Two families came in search of

better medical care for small children, but they were also seeking refuge from what they described as life-threatening situations. Two came primarily to support their families and one, whose sponsorship fell through, to join a long-separated husband. Despite having good educations and holding 'white collar' jobs in their home countries, study participants generally were working in one or more underpaid manual jobs in janitorial services, construction, factory work or informal caregiving without job protection or benefits.

Although all participants had entered Canada legally, had attempted to follow correct immigration procedures and had been waiting months or years for immigration decisions at the time of the interview, most feared deportation and considered themselves to be without secure status. Of the five who came on visitor's visas (that had expired), two were awaiting approval of family sponsorship, one was awaiting a visa extension, and one hoped to stay in Canada on Humanitarian and Compassionate grounds. One had entered Canada on a visitor's visa due to lack of knowledge of refugee asylum procedures and had just received permanent status. The other six participants (who had entered as refugee claimants) were "in the system" awaiting hearings or the outcome of last-resort options.

The psychological toll of ongoing insecurity was evident. One man who was asked how the situation affected him said,

"It affects us all the time, because when I go to work for any reason I could be arrested by the police or somebody else.... A little stress, every day. You wake up and you're always stressed out, because you fear that something could happen ..."

Almost all participants described health problems and demonstrated emotional distress from chronic stress, depression, trauma and family separation. For example, one woman who left Mexico due to sexual trauma, marital rape and the medical needs of her young son, and was uncertainly awaiting a refugee hearing, said,

"Because I'm far away from my family, the last couple of months I had depression.... (she begins to cry). That's what I think it is. There is a time I only wanted to sleep. ...It's hard for me... But also, I wasn't going to risk either my son's or my life."

Several women had experienced sexual violence in the home country and some, difficult or humiliating encounters with officials or service providers in Canada. One woman who fled Peru due to threats from terrorists and was a failed refugee claimant in Canada (though her brother was accepted) was asked if she had any health problems. She replied,

"No. [deep sigh]... I have problems, but the worry is about whether or not I'll have to go back. That's why I start having a lot of headaches and also the worry about what's going to happen to my children.... A lot of things have happened down there.... It's like starting all over again, to talk about it, and I want the past to be in the past"

The woman added, *"Sometimes I feel like I don't have the right to feel sick."* She also described how she felt when seeking care in a hospital:

"...The [nurse] looked at my immigration papers, like giving them a second thought about giving me medical attention. She had to make a phone call, after seeing my papers. I felt like some discrimination about it...."

Beyond individual health effects, the greatest impact of having irregular status appeared to be on the family, specifically increased emotional stress for children. For example, a failed refugee claimant from Argentina whose child's health was unstable said,

"I was working from morning to night. My son started showing signs of stress, because of the situation in which we were living. We didn't know how to make plans for our future. We didn't know where the future would take us. Between this insecure situation and my husband without work – without a social insurance number or a work permit – the situation in my house was one of nervousness. [Our son] started to show signs of depression.... When it happened that we had to leave, that was terrible, he started to show symptoms of stress again, wetting his bed, staying home from school...."

All but one of the study participants were parents (or grandparents) of school-aged children. Often some members of the family, but not others, had legal status. This created differential access to health services and contributed to worries about possible family separation if family members were deported. Most participants had good social support within the

immediate family, but showed distrust of, or had limited support from, non-family members. Although some participants desired psychological counseling, most relied on active personal coping skills, rejecting the stigma of criminalization. Many made efforts to lead productive and meaningful lives, for example, by volunteering, helping elderly neighbours and coaching children's soccer, despite their lack of status.

Several themes related to accessibility of health care and impact of lack of care emerged. These included having received poor health care for children in home countries, hence a perceived need for health security in Canada; increased stress and risk of poor personal health due to lack of status; inconsistent treatment by health care providers and uncertainty of where help could be found; the financial burden of hospitalization; and language barriers. For example, one man from Costa Rica, whose visa had expired while he awaited sponsorship, described the challenges,

"The main [challenge] was language and also health. [My wife] was in the hospital for four days and they charged \$8,000. We didn't know at the beginning. We were told that if we took her to the hospital we might be deported. I'm still paying that [bill]."

Study participants perceived discrimination due to lack of legal status and felt the injustice of being hard working, but lacking rights to the same health care accorded other members of society. For example, one said,

"...80% of us who are in this situation, we all work, we pay taxes. We deserve to be attended to in the hospitals. We deserve all the attention that they give to everyone because we pay like everyone.... I feel that there is discrimination.... If we contribute, they must attend to us."

DISCUSSION

These qualitative findings may counter some prevailing assumptions about irregular migrants and suggest directions for further research and intervention. Public perceptions have made it possible to view irregular migrants unsympathetically as the illegitimate "other," and thus to more easily exclude them from public health care.³² In fact, irregular immigrants have

much in common with Convention refugees (forced migrants) in terms of reasons for migrating and unmet psychosocial health needs. Living without regular status is often a result of limited immigration options and procedural barriers within a climate of state control,^{33,34} rather than immigrants' intent to circumvent the laws of Canada. Access to essential health care is often tied to illogical bureaucratic rules and is a distressingly complex matter for mixed-status families. Although irregular immigrants show resilience in maintaining a work ethic and moral self-image, emotional distress related to their insecure situation is significant.

Raising awareness of the challenges that irregular immigrants face and increasing the availability of community mental health services may help. More comprehensive information about this growing population is needed for health promotion, provision of mental health services and fair, evidence-based policy formulation.

REFERENCES

- McKee M, Janson S. Forced migration: The need for a public health response *Eur J Public Health* 2001;11:361.
- Torres AM, Sanz B. Health care provision for illegal immigrants: Should public health be concerned? *J Epidemiol Community Health* 2000;54:478-79.
- Ku L, Matani S. Left out: Immigrants' access to health care and insurance. *Health Affairs* 2001;20:247-56.
- Roer-Strier D, Olshatin-Mann O. To see and not be seen: Latin American illegal foreign workers in Jerusalem. *Int Migration* 1999;37(2):414-36.
- Goldman DP, Smith JP, Sood N. Legal status and health insurance among immigrants. *Health Affairs* 2005;24:1640-53.
- Goldman D, Smith J, Sood N. Immigrants and the cost of medical care. *Health Affairs* 2006;25:1700-11.
- Wayland S. Unsettled: Legal and Policy Barriers for Newcomers to Canada. A joint initiative of Community Foundations of Canada and the Law Commission of Canada, 2006. Available online at www.cfc-fcc.ca (Accessed May 28, 2006).
- Gagnon A. Responsiveness of the Canadian health care system towards newcomers. Discussion paper no. 40, Commission on the Future of Health Care in Canada, 2002.
- Sales R. The deserving and the undeserving? Refugees, asylum seekers and welfare in Britain. *Critical Soc Pol* 2002;22(3):456-78.
- Steel Z, Frommer N, Silove D. Part I-The mental health impacts of migration: The law and its effects. Failing to understand: Refugee determination and the traumatized applicant. *Int J Law Psychiatry* 2004;27:511-28.
- Papademetriou D. The global struggle with illegal migration: No end in sight. Migration Information Source, September 1, 2005, Washington, DC: Migration Policy Institute.
- Oxman-Martinez J, Hanley J, Lach L, Khanlou N, Weerasinghe S, Agnew V. Intersection of Canadian policy parameters affecting women with precarious immigration status: A baseline for understanding barriers to health. *J Immigrant Health* 2005;7(4):247-58.
- Caulford P, Vali Y. Providing health care to medically uninsured immigrants and refugees. *CMAJ* 2006;174:1253-54.
- Gushulak B, Macpherson D. Health issues associated with the smuggling and trafficking of migrants. *J Immigrant Health* 2000;2:67-78.
- Kirby M. Final Report: Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada. Standing Senate Committee on Social Affairs, Science and Technology, Canada, 2006.
- Mehta C, Nik T, Mora I, Wade J. Chicago's Undocumented Immigrants: An Analysis of Wages, Working Conditions, and Economic Contributions. Centre for Urban Economic Development, University of Illinois at Chicago, 2002.
- Berk M, Schur C. The effect of fear on access to care among undocumented Latino immigrants. *J Immigrant Health* 2001;3:151-56.
- Reijneveld S, Verheij R, van Herten L, de Bakker D. Contacts of general practitioners with illegal immigrants. *Scand J Public Health* 2001;29:308-13.
- Law S, Hutton M, Chan D. Clinical, social and service use characteristics of Fuzhounese undocumented immigrant patients. *Psychiatric Services* 2003;54(7):1034-37.
- Aroian K. Health risks and problems encountered by illegal immigrants. *Issues in Mental Health Nursing* 1993;14:379-97.
- Koser K. Asylum policies, trafficking and vulnerability. *Int Migration* 2000;38(3):91-111.
- Chavira P. Out-of-status person's access to health care: A cross-sectional survey in 19 cities of 7 European countries, Paper presented at the 5th International Urban Health Conference, Amsterdam, The Netherlands, October 2006.
- Friere M. Issues of Access to Services for Undocumented Individuals and their Children, Testimony of M. Friere, Chief Psychiatrist, Toronto Board of Education, Presentations to the Advisory Committee on Immigration and Refugee Issues in Toronto, Toronto City Hall, May 3, 1999.
- Nyers P. Access not fear: Non-status immigrants and city services: A preliminary report, 2006 (unpublished).
- Khanlou N, Mill C. Precarious immigration status: Exploring impacts on health, Paper presented at the 10th International Metropolis Conference, Toronto, October 2005.
- Chavez L. *Shadowed Lives: Undocumented Immigrants in American Society*. Fort Worth, TX: Holt, Rinehart and Winston, 1992.
- Nijhawan M. Deportability, medicine, and the law. *Anthropology & Med* 2005;12(13):271-85.
- Denzin N, Lincoln Y. Introduction: Entering the field of qualitative research. *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage Publications, 1994;3.
- Silove D, Coello M, Tang K, Aroche J, Soares M, Lingam R, et al. Towards a researcher-advocacy model for asylum seekers: A pilot study amongst East Timorese living in Australia. *Transcultural Psychiatry* 2002;39(4):452-68.
- Patton MQ. *Qualitative Evaluation and Research Methods*, 2nd ed. Newbury Park, CA: Sage Publications, 1990.
- Beiser M. The health of immigrants and refugees in Canada. *Can J Public Health* 2005;96(Suppl. 2):S30-S44.
- Grove N, Zwi A. Our health and theirs: Forced migration, othering and public health. *Soc Sci Med* 2006;62:1931-42.
- Watters C, Ingleby D. Locations of care: Meeting the mental health and social care needs of

refugees in Europe. *Int J Law Psychiatry* 2004;27:549-70.

34. Fassin D. Social illegitimacy as a foundation of health inequality: How the political treatment of immigrants illuminates a French paradox. In: Castro A, Singer M (Eds.), *Unhealthy Health Policy: A Critical Anthropological Examination*. Walnut Creek, CA: Altimira Press, 2004.

Received: June 21, 2006

Accepted: January 29, 2007

RÉSUMÉ

Contexte : Cette étude qualitative examine les expériences des personnes vivant à Toronto et n'ayant pas le statut d'immigrant régulier ainsi que les répercussions que cela peut avoir sur leur santé. Les immigrants irréguliers sont ceux qui n'ont pas de statut au Canada. Ils comprennent les visiteurs qui ne repartent pas une fois leur visa de séjour expiré, les demandeurs du statut de réfugié en attente d'une réponse et les demandeurs de statut de réfugié qui n'ont pas été acceptés et qui restent au pays sans autorisation, qui attendent d'être déportés ou qui ont recours à d'autres procédures parce qu'ils ne peuvent pas faire appel de la décision.

Méthodes : Des entrevues approfondies et semi-structurées ont été effectuées auprès d'immigrants irréguliers dans un centre de santé communautaire du centre-ville. Des transcriptions des entrevues ont été codées et analysées à l'aide d'une théorie à base empirique et de techniques analytiques qualitatives. Le cadre théorique reposait sur les métaphores anthropologiques de liminalité et examinait les facteurs psychosociaux associés au stress.

Résultats : Les expériences constatées dans l'échantillonnage de l'étude contredisent les suppositions généralement entretenues sur les immigrants irréguliers. La majorité des participants sont venus au Canada pour fuir la violence et l'incertitude économique de leur pays d'origine d'Amérique latine et la plupart ont essayé de suivre les procédures d'immigration en règle. Ce sont pour la plupart des parents qui sont exploités dans des emplois peu rémunérés. Ils ont tenté de mener une vie productive et constructive, mais ne bénéficient pas d'un soutien social autre que celui de leur famille immédiate. Ils présentent des symptômes de traumatismes, de dépression, de stress chronique, de séparation familiale et de maladies physiques liées au stress. Bien qu'ils affichent une bonne estime de soi et qu'ils aient de bons mécanismes d'adaptation, ils sont nombreux à déclarer avoir des besoins non comblés en matière de santé et faire face à des obstacles au moment de chercher de l'aide. Au-delà des répercussions sur le plan personnel, le fait de vivre sans statut semble surtout avoir des effets négatifs sur la famille, et plus particulièrement sur les enfants.

Conclusions : Il nous faut recueillir davantage d'information sur cette population croissante aux fins de la promotion de la santé, de la prestation de services de santé mentale et de l'élaboration de politiques équitables.

Participez à l'Initiative canadienne d'immunisation internationale (ICII)

Nous cherchons les gens comme vous avec une vaste expérience de l'immunisation, de la surveillance de maladies, de l'épidémiologie ou des programmes de gestion de données et qui ont déjà vécu une expérience interculturelle. La capacité de travailler en français et dans d'autres langues est un atout important.

Pour renseignements, contactez
ciii@cpha.ca
où visitez notre site Web :
<http://ciii.cpha.ca>

Get Involved with the Canadian International Immunization Initiative (CIII)

We are looking for people like you with extensive experience in immunization, disease surveillance, epidemiology or data management programs who have cross-cultural experience. If you can work in French and any other languages, this will be extremely helpful.

For information, please contact the Canadian International Immunization Initiative at
ciii@cpha.ca or visit our website at
<http://ciii.cpha.ca>

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.